Complete Summary

TITLE

Ischemic heart disease: percent of patients with previous acute myocardial infarction (AMI) and low-density lipoprotein cholesterol (LDL-C) greater than or equal to 120 on most recent test in past two years (lower is better) (NEXUS clinics, outpatient heart failure, AMI follow-up, SCI&D, and SMI cohorts).

SOURCE(S)

Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. 244 p.

Brief Abstract

DESCRIPTION

This measure assesses the percent of patients with previous acute myocardial infarction (AMI) and low-density lipoprotein cholesterol (LDL-C) greater than or equal to 120 on most recent test in the past two years (lower is better).

RATIONALE

The Adult Treatment Panel III (ATP III) of the National Cholesterol Education Program issued an evidence-based set on cholesterol management in 2001. Since the publication of ATP III, 5 major clinical trials of statin therapy with clinical endpoints have been published. The results of these recent trials have certain implications for cholesterol management. Therapeutic lifestyle changes (TLC) remain an essential modality in clinical management. The trials confirm the benefit of cholesterol lowering therapy in high-risk patients and support the ATP III treatment goal of low-density lipoprotein cholesterol (LDL-C) less than 100 mg/dL. They support the inclusion of patients with diabetes in the high-risk category and confirm the benefits from LDL-lowering therapy in these patients. They further confirm that older persons benefit from therapeutic lowering of LDL-C. The major recommendations for modifications to footnote the ATP III treatment algorithm are the following: In high-risk persons, the recommended LDL-C goal is less than 100 mg/dL. But when risk is very high, an LDL-C goal of less than 70 mg/dL is a therapeutic option (reasonable clinical strategy) on the basis of available clinical trial evidence. This therapeutic option extends also to patients at very high-risk who have baseline LDL-C less than 100 mg/dL. Moreover, when a

high-risk patient has high triglycerides or low high-density lipoprotein cholesterol (HDL-C), consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. For moderately high-risk persons (2+ risk factors and a 10-year risk 10% to 20%) the recommended LDL-C goal is less than 130 mg/dL, but a LDL-C goal less than 100 mg/dL is a therapeutic option on the basis of recent trial evidence. The latter option extends also to moderately high-risk persons with a baseline LDL-C of 100 to 129 mg/dL. When LDL-lowering drug therapy is employed in high-risk or moderately high-risk persons, it is advised that the intensity of therapy be sufficient to achieve at least a 30% to 40% reduction in LDL-C levels. Moreover, any person ay high-risk or moderately high-risk who has lifestyle related risk factors (e.g., obesity, physical inactivity, elevated triglycerides, low HDL-C, or metabolic syndrome) is a candidate for TLC to modify these risk factors regardless of LDL-C levels. Finally, for people in lower risk categories, recent clinical trials do not modify the goals and cutpoints for therapy.

In the presence of existing evidence and because clinicians must individualize a patient lipid management treatment plan based upon risk, Veterans Administration (VA) will measure the intermediate outcome of percent of patients with LDL-C less than 100 and LDL-C greater than or equal to 120.

PRIMARY CLINICAL COMPONENT

Ischemic heart disease; acute myocardial infarction (AMI); low-density lipoprotein cholesterol (LDL-C)

DENOMINATOR DESCRIPTION

Patients whose previous acute myocardial infarction (AMI) is older than 60 days (see the related "Denominator Inclusions/Exclusions" field in the Complete Summary)

NUMERATOR DESCRIPTION

The number of patients from the denominator with low-density lipoprotein cholesterol (LDL-C) greater than or equal to 120 (see the related "Numerator Inclusions/Exclusions" field in the Complete Summary)

Evidence Supporting the Measure

PRIMARY MEASURE DOMAIN

Process

SECONDARY MEASURE DOMAIN

Not applicable

EVIDENCE SUPPORTING THE MEASURE

A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

NATIONAL GUIDELINE CLEARINGHOUSE LINK

- VA/DoD clinical practice guideline for management of ischemic heart disease.

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Use of this measure to improve performance

EVIDENCE SUPPORTING NEED FOR THE MEASURE

Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. 244 p.

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

External oversight/Veterans Health Administration
Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Ambulatory Care

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Advanced Practice Nurses
Physician Assistants
Physicians

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Single Health Care Delivery Organizations

TARGET POPULATION AGE

Unspecified

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

Acute coronary syndrome (ACS) is the leading cause of morbidity and mortality among both men and women in the United States, affecting more than 13.9 million people. The acute presentation of ACS is varied, with acute myocardial infarction (AMI) being the most dramatic of presentations. Annually, AMI affects approximately 1.1 million people in the United States. The mortality rate with AMI is approximately 30%. About once every 29 seconds, an American suffers a coronary event, and about every minute, someone dies from one.

EVIDENCE FOR INCIDENCE/PREVALENCE

Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. 244 p.

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

See "Incidence/Prevalence" field.

UTILIZATION

Unspecified

COSTS

Unspecified

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

Patients from the following cohorts are eligible for inclusion: Random NEXUS Clinics, Outpatient Heart Failure, Acute Myocardial Infarction (AMI) Follow-up, Spinal Cord Injury & Disorders (SCI&D), and Seriously Mentally Ill (SMI)*

*Refer to the original measure documentation for patient cohort descriptions.

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR (INDEX) EVENT

Clinical Condition
Diagnostic Evaluation

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
Patients* whose previous acute myocardial infarction (AMI)** is older than 60 days

*Patients from the following cohorts are eligible for inclusion: Random NEXUS Clinics, Outpatient Heart Failure, AMI Follow-up, SCI&D, and SMI. Refer to the original measure documentation for patient cohort descriptions.

**International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code 412 in any position

Exclusions
Unspecified

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
The number of patients from the denominator with low-density lipoprotein cholesterol (LDL-C) greater than or equal to 120*

*LDL-C on most recent test in the past two years. Full lipid panel is not required for this measure.

Exclusions
Unspecified

DENOMINATOR TIME WINDOW

Time window precedes index event

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Administrative data
Laboratory data
Medical record

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a lower score

ALLOWANCE FOR PATIENT FACTORS

Unspecified

STANDARD OF COMPARISON

Internal time comparison
Prescriptive standard

PRESCRIPTIVE STANDARD

Fiscal year (FY) 2005 targets for low-density lipoprotein cholesterol (LDL-C) greater than or equal to 120 (NEXUS Clinics, Outpatient Heart Failure, AMI Follow-up, SCI&D, and SMI cohorts):

- Meets Target: 22% (lower is better)
- Exceeds Target: 20% (lower is better)

EVIDENCE FOR PRESCRIPTIVE STANDARD

Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. 244 p.

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Ischemic heart disease (IHD): patients with LDL-C greater than or equal to 120 (lower is better).

MEASURE COLLECTION

Fiscal Year (FY) 2005: Veterans Health Administration (VHA) Performance Measurement System

MEASURE SET NAME

Cardiovascular

MEASURE SUBSET NAME

Ischemic Heart Disease

DEVELOPER

Veterans Health Administration

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

2003 Nov

REVISION DATE

2005 Mar

MEASURE STATUS

This is the current release of the measure.

SOURCE(S)

Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. 244 p.

MEASURE AVAILABILITY

The individual measure, "Ischemic Heart Disease (IHD): Patients with LDL-C Greater Than or Equal to 120 (Lower is Better)," is published in "FY 2005 VHA Performance Measurement System: Technical Manual."

For more information contact:

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NQMC STATUS

This NQMC summary was completed by ECRI on November 29, 2004. The information was verified by the measure developer on December 10, 2004.

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